Cook County's Healthcare Safety Net: Local Market Realities, Vulnerabilities and Strategies

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Agenda

1. Impact of locoregional mergers, consolidations, acquisitions
2. Service Accessibility Issues for Vulnerable Communities
3. IL Hospital Assessment Program and Transformation
4. Strategic Recommendations

Impact of Mergers, Consolidations, Acquisitions

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Acute care hospital business is low margin

Illinois Health and Hospital Association data

- 42% of Illinois hospitals operating in red or on margin <2%
- Higher proportion in Chicago area

Consolidation is a dominant motif in the current Hospital landscape

The most vulnerable are most impacted by these changes

The major private systems focus on geographies with a better payer mix for populations

- AdvocateAuroraHealth (27 hospital system)
- Northwestern (Centegra, Cadence-10 hospital system)
- Trinity (Loyola/Gottlieb/MacNeal/pending Palos; Mercy)
- AMITA (Ascension, inc. former Presence/Adventist)
- University of Chicago Medicine (Ingalls)
- Franciscan Health

Recent Hospital Acquisitions

January 2019: for-profit Tenet Healthcare sold Westlake (Melrose Park), Weiss (Uptown), and West Suburban (Oak Park/Austin) hospitals to for-profit Pipeline Health.

Pipeline subsequently announced Westlake will close by July 2019.

Hospital Closures in Cook County

36 hospitals have closed in Cook County since 1982.

1980s

- **1982**
  - Chicago Eye ENT Hosp & Med Ctr
- **1985**
  - Chicago Ctr Hosp
  - Henrotin Hosp
  - Salvation Army Booth Hosp
- **1987**
  - Provident Med Ctr
  - Walther Memorial Hosp
- **1988**
  - Frank Cuneo Memorial Hosp
  - Hosp of Englewood
  - Mary Thompson Hosp
- **1989**
  - Lutheran General Hosp-Linc Park
  - Mt Sinai Hosp Med Ctr – North
  - St Anne's Hosp

1990's

- **1990**
  - Central Community Hosp
- **1991**
  - Lakeside Community Hosp
  - Martha Washington Hosp
- **1992**
  - Parkside Lutheran Hosp
- **1996**
  - CPC Old Orchard Hosp
  - Chicago Osteopathic Hosp
  - St Cabrini Hosp
  - Univ Student Health Service
- **1997**
  - Columbia Chicago Lakeshore Hosp
  - Metro Child & Adolescent Inst
  - Univ Hosp

2000's

- **2000**
  - Doctors Hosp of Hyde Park
  - Forest Hosp
- **2001**
  - Columbus Hosp
  - Edgewater Med Ctr
- **2002**
  - Advocate Ravenswood Med Ctr
  - Rock Creek Ctr
- **2008**
  - Lincoln Park Hosp
- **2009**
  - Michael Reese Hosp
  - Neurologic & Orthopedic Inst

2010's

- **2011**
  - Oak Forest Hosp of Cook County
- **2012**
  - Tinley Park Mental Health Ctr
- **2013**
  - Sacred Heart Hosp
- **2018**
  - Franciscan Health – Chicago Heights

Service Accessibility Issues for Vulnerable Communities

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Consolidation effect

The most vulnerable are most impacted by these changes

System consolidation is creating “access deserts” in vulnerable communities.

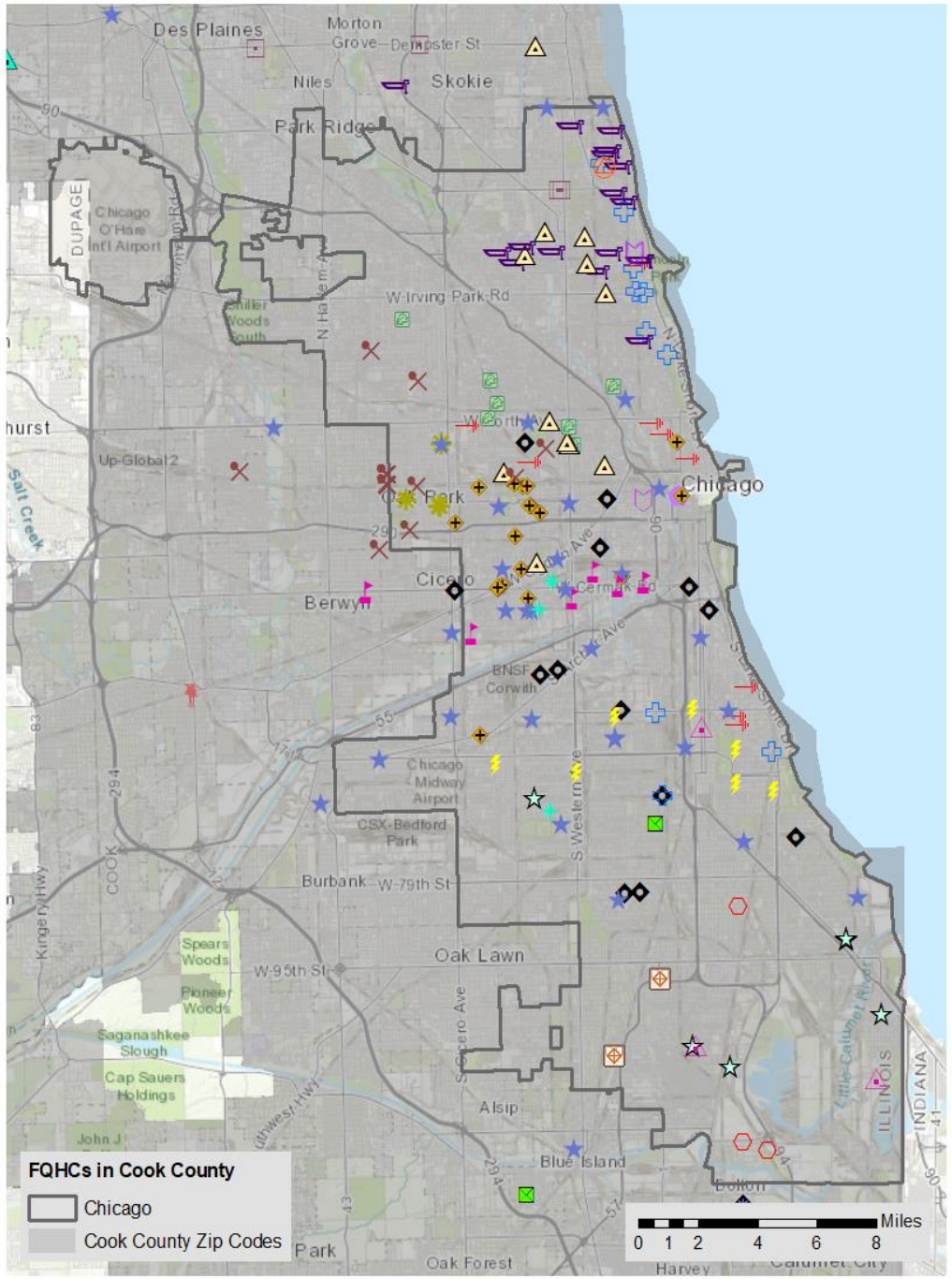
Independent hospitals struggle

- Decreasing trends in inpatient utilization
- Community choices
- Funding streams changing
- larger systems show no interest in acquiring them

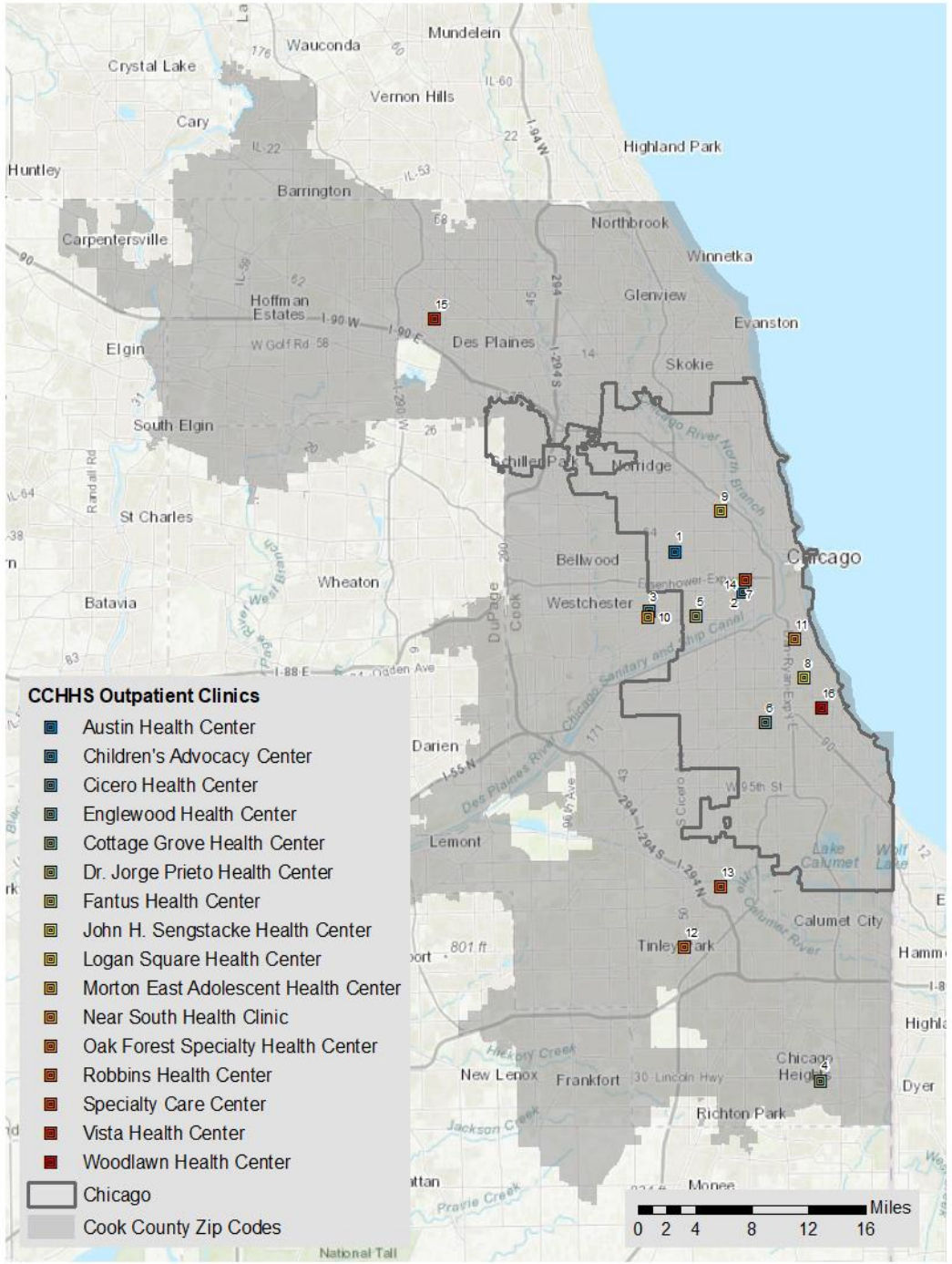
FQHC Locations in Cook County

Access to primary care is generally available through federally qualified and CCH health centers

Better in city, suburbs still challenging esp. with limited public transportation



CCH Outpatient Health Center Locations in Cook County



Inpatient Capacity is more than sufficient

- In line with the national trend, inpatient utilization for all Illinois hospitals has declined steadily.
- Inpatient utilization dropped across all Illinois hospitals dropped from 2013 -2017.
  - 4% for all IL hospitals
  - 12% for Safety Net hospitals
- Median inpatient occupancy of staffed beds across all hospitals in Illinois is 46% (2016).
- Safety net occupancy rates are similar despite significant recent reductions in staffed beds.
- Academic health centers and large non-profits have seen higher occupancy rates

IL Hospital Assessment Program & Transformation

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Hospital Assessment Program

History

- Since 2014, a portion of those funds flow through Managed Care Organizations (had been in add-ons under fee-for-service)
- Significant proportion of state payments in Medicaid program generated by the program
- Why CMS wanted it to change
- Since 2018, significantly more dollars flowed into rate payments from MCOs

Shifting Assessment Dollars to Claims Payment

Impact of the 2018 spring assessment law

- The law allowed the Department of Healthcare and Family Services to convert $635 million in hospital assessment-funded static payments to claims based payments effective July 1, 2018 (“Phase I”).
- For some low Medicaid-volume safety nets, this resulted in a net reduction of millions of dollars in revenue.
- The law authorizes the Department to move additional dollars from program to claims based payments effective July 1, 2020 (“Phase II”).
- Additional transformation will move increasing amounts of dollars to claims-based payments (“follow the patient”).
- These challenges pose significant challenges to low volume hospitals.

The Hospital Transformation Fund

Another dimension of the 2018 assessment law

- $262 million dollars of current Medicaid funds currently go to a subset of hospitals as static “transition payments”
- The law designated these dollars be available as a transformation pool hospitals *may apply for receiving* in 2020
- The strategy is that safety net hospitals would transform in ways that bring value to CMS and the community
- Criteria for transformation funding discussed but currently at a standstill
    - Providers, IL Health and Hospital Association, IL Healthcare and Family Services, legislative workgroup will need to find consensus

What is a Safety Net Hospital?

Defined by 305 ILCS 5/5-5e.1

(Criteria for safety-net hospital status)

A Safety-net hospital is an Illinois hospital that:

- (a) Is licensed by the Department of Public Health as a general acute care or pediatric hospital, and
- (b) Is a Disproportionate Share hospital, as described in Section 1923 of the federal Social Security Act and
- Meets one of the following criteria:
  - (c) Has a Medicaid inpatient utilization rate (MIUR) of at least 40% and a charity percent of at least 4%, or
  - (d) Has a MIUR of at least 50%
- "Beginning July 1, 2012 and ending on June 30, 2018, a hospital that would have qualified for the rate year beginning October 1, 2011, shall be a Safety-Net Hospital."

*MIUR=Medicaid inpatient utilization rate

(Medicaid insured days/total inpatient days)

A snapshot (from 2017)

Smaller volumes at Cook County safety nets a challenge

Hospital	Average daily census	Emergency visits	Deliveries	Surgeries
A	79	28,085	191	1271
B	55	8,024	0	601
C	71	14,902	0	1664
D	51	20,395	177	489
E	93	36,486	758	1880
F	105	29,959	632	1650
CCH	334	143,716	1,215	14,249

Source: IL Department of Public Health

Are Healthier Hospitals Shunning or Managing Medicaid?

Hospital	MIUR*	Medicaid Days	Average Daily Census
Northwestern	20.53%	32,000	410
Rush	25.77%	40,800	263
University of Chicago	38.55%	54,600	331
Advocate Trinity	44.56%	16,600	84
Advocate Christ	24.72%	50,000	379
Advocate Lutheran Gen	18.59%	25,000	270
Mercy	52.00%	33,200	110
Little Company	26.45%	14,800	133
Jackson Park	74.81%	24,000	48
Roseland	68.30%	12,600	38
Stroger	**37.79%**	**36,100**	**212**

The Net Impact of Trends

These trends will combine to severely threaten independent safety nets:

- The ongoing national decline in inpatient services
- Lack of outpatient capacity
- Movement of funds to claims based payments
- Very low number of staffed beds
- Challenges with maintaining a deep medical staff
- Alternative payment models based on outcomes
- Emphasis on the full continuum of care including social determinants

The only system with a willingness to embrace these communities is CCH.

Strategic Recommendations

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What is Needed? What can CCH uniquely provide?

- We have a broad, deep, dedicated medical staff that is mission-aligned
- We have a shared, mature electronic health record, and increasing ability to integrate within that system.
- We have invested in technology over time.
- We have a well of trust in the communities we serve.

What is Needed? What can CCH uniquely provide?

CCH can provide the full continuum of care

- Specialty care
- Chronic disease management
- High end diagnostics
- Addressing the social determinants of health
- Robust care coordination

Multi-Specialty Practice Groups

On the rise nationally-why?

1. **Better communication among your physicians**. Seeing aligned doctors promotes collaboration and ensures more efficient care. Medical groups utilize a common EHRs that facilitate sharing of information. Improved communication helps improve outcomes.

2. **Access to new treatments and technology**. Not only will do MSPGs provide access to additional physicians and experts, but increased access to new treatments and technologies as well. Integrated medical groups combine the assets of a particular health care organization.

3. **Coordinated care**. Integrated medical groups employ physicians who practice in hospital and ambulatory settings, mitigating potential disruption in care when being admitted or discharged. Working as a team improves efficiency and quality.

4. **Higher standards of quality monitoring**. Integrated medical groups have more resources to devote to monitoring and improving the care provided.

5. **Additional clinical resources**. As part of a broader health system, physicians in an integrated group can draw on a wider array of clinical services. These may include things like home care, diabetes education, smoking cessation, cardiac rehabilitation, and others. It's no longer just visiting your doctor when you are sick.

Nash, MD, Ira. (2018). Five benefits of integrated medical groups. *Northwell Health*. Available at: https://www.northwell.edu/news/five-benefits-of-integrated-medical-groups

Strategic Recommendations

Where do we go from here?

- We must be prepared for stressors in hospital environment.
- Economics of Medicaid will continue to cause challenges for privates and not-for-profits, but in perhaps unpredictable ways.
- The communities with vulnerable populations more likely need access to specialty and diagnostic services (perhaps Urgent Care) more than acute care hospital beds.
    - We will need to significantly improve access to specialty and diagnostic services.
    - We will need to develop technologic innovations to assist in services to patients in areas poorly served by public transportation, including telemedicine and care coordination.
    - We must improve the patient experience as we must have revenue from insured patients to offset the costs of our system.
- We do not have an infinite capacity for Charity Care

Thank You

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